



Sikle Cell Anemia

Name _____ Date of Birth: _____
Height: _____ Weight _____ Sex: M/F
Tobacco usage: _____ Face Amount: _____
____ Term 10 15 20 30 ____ UL

1. When was Sikle Cell Anemia diagnosed? _____

2. What type of sickle cell anemia does your client have?
 Sickle cell (SS) Sickle cell (SC) Sickle cell trait (SA) Hemoglobin C

3. Is there a history of complications? Yes No
(If yes, check those that apply and give the date of the last episode)
 Painful crisis Date: _____
 Aseptic recrosis of bones Date: _____
 Leg ulcers Date: _____
 Lung scarring Date: _____
 Thrombosis Date: _____
 Enlarged heart Date: _____
 Other (Please describe) _____

4. What is the current hemoglobin? _____

5. Are there other medical conditions? Yes No
If yes, please list: _____

6. Is the proposed insured taking medication for this condition or any other? Yes No
(If yes, please provide the name, dosage, and frequency): _____

